UNITED STATES DISTRICT COURT FOR THE
EASTERN DISTRICT OF CALIFORNIA

Jamie Osuna, CDCR #BD0868 PO Box 3476 Corcoran, CA 93212 Pl., against T. Campbell, B. McKinney, A. Johnson, T. Sparks, D. Watson, A. Aranda, E. Moreno, S. Gates, S. Harris, A. Aranda, A. Johnson, A. Vu, E. McDaniel, M. Whittaker, C. Soares, et al Defs.	Docket No.: 1:24-cv-01156-JLT-EPG First Amended Complaint Pursuant to FRCP 15a to correct Pl.'s newly found defects, mistakes in the original complaint. **DEMAND FOR JURY TRIAL** **COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF, COMPENSATORY AND PUNITIVE DAMAGES** Brought under 42 U.S.C. § 1983 (civil rights action) for violations of the U.S. Constitution.

JURISDICTION & VENUE

1. This is a civil rights action arising under 42 U.S.C. § 1983 to redress the deprivation under the color of state law of rights, privileges, and immunities guaranteed by the Eighth Amdt. to the U.S. Constitution, secured by acts of Congress, providing for equal rights of persons within the jurisdiction of the U.S. This Court has jurisdiction over this action pursuant to 28 U.S.C. §§ 1331, 1343 (a)(3). This Court has jurisdiction over Pl.'s action and is empowered to grant injunctive relief pursuant to Fed. R. Civ. P. 65 and may exercise supplemental jurisdiction under 28 U.S.C. § 1367.

2. Venue is proper in this judicial district, the Eastern District of California, Fresno Division, pursuant to 28 U.S.C. § 1391 (a)(b) because a substantial part of the events and actions and omissions giving rise to Pl.'s claims occurred at CSP-COR, California Department of Corrections (CDCR), in Corcoran, CA, Kings County, which is within this judicial district.

INTRODUCTION

3. Pl. is hereby filing his first amended complaint under FRCP 15a. Pl. recently observed mistakes and newly found defects in his original complaint. This is a § 1983 civil rights action brought by Jamie Osuna, a state prisoner, for declaratory and injunctive relief, compensatory and punitive damages under 42 U.S.C. § 1983 alleging being subjected to unsafe conditions of

confinement with/of dangerous, hazardous living conditions, denial of reasonable safety needs, denial of medical care, and for deliberate indifference to Pl.'s serious medical/mental health needs. These above-described unsafe conditions of confinement and deliberate indifference contributed to Pl.'s significant injuries he sustained daily on his body, which injuries were consistent with untreated decompensation. This lack of intervention/treatment led to injuries after Pl. was left in a cell for four months with two broken windows and glass everywhere. Pl.'s cell floor was soaked with blood, covered with bloody rags, other bloody debris. These above-described conditions were visible to CSP-COR Defs. everyday for four months without intervention/treatment, against state/CDCR protocols and policies and in violation of Pl.'s Eighth Amdt. rights guaranteed under the U.S. Constitution.

4. Due to Pl.'s intellectual hardship of being under PC 2602 orders, schizophrenia-type mental illnesses, SHU/RHU housing, Pl. received help with the transcribing/writing of this complaint.

PARTIES

5. Pl. Jamie Osuna is a state prisoner incarcerated at CSP-COR, Corcoran, CA.
6. Def. T. Campbell, Warden, is being sued in her individual, official capacities.
7. Def. B. McKinney, Associate Warden/AW, is being sued in her individual, official capacities.
8. Def. E. (Enrique) Moreno is a Lt. and is being sued in his individual, official capacities.
9. Def. T. (Tiffany) Sparks(-Mendoza) is a Mental Health Supervisor and is being sued in her individual, official capacities. CA license # 77726; Board of Behavioral Sciences.
10. Def. S. (Scott) Harris is CSP-COR's Chief of Mental Health (CMH) and is being sued in his individual, official capacities. CA license # 22416; Board of Psychology.
11. Def. A. (Alonzo) Aranda is a Lt. and is being sued in his individual, official capacities.
12. D. (Daniel) Watson is a licensed clinical social worker and is being sued in his individual, official capacities. CA license # 81005; Board of Behavioral Sciences.
13. Def. A. (Andrew) Johnson is a Cpt. and is being sued in his individual, official capacities.
14. Def. A. (Alan) Vu is a medical doctor and staff psychiatrist and is being sued in his individual, official capacities. CA license # 76543.
15. Def. S. (Sara) Gates is CDCR's Chief of medical/mental health care, based in Sacramento, CA,

and is being sued in her individual, official capacities.

16. C. (Clint J.) Soares is a Chief Psychologist and is being sued in his individual, official capacities. CA license # 18782; CA Board of Psychology.

17. Def. E. (Eric) McDaniel is CEA and is being sued in his individual, official capacities.

18. Def. M. (Michael) Whittaker is CSP-COR's Health Care CEO and is being sued in his individual, official capacities.

19. Defs. (John/Jane) Does, 1-TBD, were/are CDCR personnel and are being sued in their individual, official capacities.

EXHAUSTION OF ADMINISTRATIVE REMEDIES

20. Pl. has exhausted his administrative remedies with respect to all claims and all Defs. CDCR issued log # / health care grievance # 397422/COR-HC-23000809 for Pl.'s grievance for jurisdiction of mental health/medical staff, which was exhausted at all levels in CDCR.

FACTUAL STATEMENT

21. On or around 01/10/2023, Pl. was discharged from CSP-COR's Crisis Unit after an around 30-day in-patient admission for Pl. displaying dangerous symptoms/side effects from PC 2602 forced psychotropic, antipsychotic medications. Pl. has been under continual PC 2602 orders since around 2020 for serious mental illnesses, being deemed a danger to self/others and gravely disabled (e.g., all the determining markers required for a PC 2602 order.)

22. On or around 01/10/2023, Pl. was rehoused/assigned to CSP-COR SHU/RHU.

23. On or around 01/15/2023, Pl. displayed mental health symptoms and was escorted to the unit shower, where Pl. attempted to self-harm. Pl. was caught and was unsuccessful.

24. R. Esquivel (CO) escorted Pl. back to his cell. Pl. broke Pl.'s cell window; sharp glass shards flew everywhere. Pl. was issued a rules violation report (RVR) log # 7260116 for this incident.

25. The same day, Pl. began cutting himself with glass shards from the broken window.

26. On or around 01/28/2023, Pl. continued to use the glass shards to cut himself. The blood all over Pl.'s floor and bloody rags/debris were visible to custody and clinical staff through the cell door window and cell door.

27. On or around 01/28/2023, Pl. was escorted to a visit. The cuts on Pl.'s legs and arms, as well

as blood and bloody rags/debris were visible to custody staff who were located by the door.

28. Around 11 am to 12:45 pm, F. Camacho was walking the tier when she saw Pl.'s cell door open and noticed the blood.

29. F. Camacho stated, "Is that blood? Is anybody gonna clean this shit up?" F. Camacho then called to R. Muhammed to look at the floor and the blood that was soaked over that concrete floor. Pl. received no treatment and no clinical intervention.

30. While Pl. was at visiting, his visitor saw the cuts on Pl.'s arms and asked Pl. why they [CSP-COR] had not intervened. That same day, Pl.'s visitor reported Pl.'s physical state/living conditions to Rosen, Bien, Galvan, & Grunfeld, LLC (RBGG) (*Coleman* Project Team.) Pl. was placed back into his cell after his visit, and Pl. cut himself with the glass shards again.

31. Around 01/30/2023, at his visitor's urging, Pl. filed a grievance requesting to be placed at higher level of care/treatment due to decompensation/trouble managing his mental health episodes and CSP-COR's mental health/other staff acting in deliberate indifference to Pl.'s health and safety. Pl. with that 602 requested body camera footage from the above-described incident and a 7219 medical/injury report.

32. Around 02/01/2023, Def. T. Sparks informed Pl. she received an email from RBGG worried about Pl. after RBGG received notice Pl. was in danger. Def. asked if Pl. was cutting and to see the wounds. Pl. showed his right arm with a 7-inch cut open into the muscle. Def. opened her eyes wide, left, returned with a psych tech who said, "Wow" in Spanish at seeing Pl.'s arm. They documented Pl.'s injuries. Def. stated that she had to find a response to the email. Pl. stated he had not been receiving any medical attention for his mental health episodes, and no one was addressing the hazards. Def. stated that all she had to do was come up with something to walk away and make RBGG go away. Def. at other times expressed her anger at Pl.'s grievances and participating in RBGG's interviews for class action Coleman v. Newsom.

33. Around 02/2024, Def. D. Watson approached Pl.'s cell for their weekly treatment meeting.

34. Pl. informed Def. that Pl. was having side effects/symptoms of Pl.'s serious mental illnesses and medications. Pl. reminded Def. of the safety claimers in Pl.'s file regarding dangerous side effects of his antipsychotic, psychotropic medications. Pl. stated Pl. was feeling agitated,

irritated, having insomnia, rapid muscle movement/nerve movements in the body that Pl. cannot control, and continued severe grinding of teeth.

35. Pl. told Def. that Pl. was still blacking out and wasn't remembering a lot that was happening, that when Pl. comes to consciousness, Pl. would find himself injured with glass stuck on his arms and the bottoms of his feet.

36. Def. stated to Pl., "Well, you can learn how to change your behavior. If you come out and talk [at talk therapy], it will be something."

37. Pl. stated to Def. these side effects are not behavioral issues that cannot be talked away, that there are permanent side effects like tardive dyskinesia (involuntary muscle movement) that Pl. was experiencing. Pl. stated that Pl. thought Pl. should be in a safer cell or treatment facility because of the broken glass everywhere, that CSP-COR isn't equipped to keep Pl. safe and unable to help Pl. manage side effects symptoms.

38. Def. stated that Def. "didn't agree" with Pl.'s diagnoses.

39. Pl. reminded Def. that CSP-COR repeatedly brings Pl. to administrative court to renew PC 2602 forced medication orders, for which CDCR's/CSP-COR's-appointed psychiatrists submit reports that Pl.'s write ups were due to Pl.'s underlying psychotic processes.

40. Pl. stated, "You're forcing me with psychotropic medications but don't want to deal with or acknowledge the side effects it's having on me or give me the proper treatment that comes with [is required for] being petitioned for PC 2602."

41. Def. stated that Def. "didn't believe in side effects" or the dangers/hazards, and that there was nothing Def. could do but talk to Pl.

42. Pl. asked Def. what about Pl.'s episodes of blacking out and the glass everywhere, blood.

43. Def. stated that Pl. "had to make changes." Def. stated Def. would let Def.'s supervisors know about the broken window and hazards/blood everywhere, and then Def. walked away.

44. During Def. D. Watson's and Pl.'s following weekly-scheduled one-on-one cell-side meeting, Def. informed Pl. that Def.'s supervisors wanted to leave Pl. in Pl.'s cell at Pl.'s current level of treatment (the lowest level of treatment available, CCC.) Pl.'s windows/cell had continued to remain in the same condition since Def.'s and Pl.'s previous meeting.

45. Pl. informed Def. D. Watson that Pl. has been cutting and experiencing various mental health symptoms/episodes since their last meeting.

46. Def. D. Watson stated, "You should come out [to talk therapy]. I'll see you next week." Def. then walked away. This continued week after week.

47. In or around the beginning of 04/2023, Pl.'s newly assigned clinician C. Angel approached Pl.'s cell. Pl.'s window was still broken, blood was everywhere in the cell, and Pl. had visible injuries on Pl.'s arm.

48. During their discussion, Pl. informed C. Angel of Pl.'s serious mental illness diagnoses (unspecified schizophrenia, psychotic disorder, mood disorder, PTSD), which a qualified neuropsychologist and CDCR-top specialist determined via extensive testing on Pl. Pl. informed Def. that Pl. has been under continual PC 2602 orders for involuntary medication, and that from these medications Pl. was experiencing severe side effects, issues.

49. C. Angel stated to Pl. that yes Pl. was on antipsychotics, and Pl. was in a bad situation/harming himself, but that Pl. was responsible for Pl.'s behaviors and that Pl. should admit this and that Pl. needed to be punished for his crimes. Def. had Pl.'s diagnoses only as a personality disorder—against CDCR's prior test results and PC 2602 petitions.

50. Pl. asked C. Angel why Pl. was stuck in that cell having serious side effects/symptoms with blacking out and broken window glass/hazards and waking up with injuries without help, and why Pl. was not allowed a higher level of treatment and kept in a safer environment.

51. C. Angel stated, "Well, I know, I know, but you at least, if something, can come to your one-on-ones [talk therapies]."

52. Pl. stated that that doesn't change his unsafe living conditions. Pl. stated that treatment talk therapy does not fix chemical side effects that Pl. was having, and it doesn't stop the injuries that were out of Pl.'s control.

53. CSP-COR mental health staff had not accepted recommendations and were not following CDCR/state policies guiding how to properly address symptoms like what Pl. experiences. CSP-COR, without new testing and without changes in industry definitions, then changed/stated Pl.'s diagnoses was only "personality disorder" enabling/justifying their

decisions for Pl. Conversely, the PC 2602 petitions CSP-COR filed listed another different diagnosis enabled the PC 2602 order.

54. C. Angel stated she would inform Def. A. Johnson about the broken window, but that there's nothing she could otherwise do.

55. After this meeting, Pl. continued to have/exhibit symptoms and side effects and continued to wake up with injuries on his body and glass stuck to him.

56. The next week, C. Angel told Pl. Defs. A. Johnson, AW and higher ups did not want to move Pl. to a safer location.

57. In or around 04/2023, Pl.'s treating psychiatrist Def. Dr. Vu. approached Pl.'s cell via telepsychiatry. (e.g., Dr. Vu's assistant came to Pl.'s cell and held up a laptop with a speaker for Pl. and Def. to remotely discuss Pl.'s mental health through the cell door over the laptop.) Def. Dr. Vu asked through this laptop how Pl. was doing.

58. Pl. asked Def. whether Pl. could be taken off PC 2602 because Pl. had been compliant with and never refused his medication and had been having side effects—including irreversible tardive dyskinesia, self-harming/desire to self harm, having blackouts where Pl. wakes up afterward with injuries. Def. Dr. Vu stated, "Well, you should come out and talk [at talk therapy sessions]. There's nothing I can do since you didn't come out." Dr. Vu then stated, "I'll see you next time." Pl. received no treatment or intervention for Pl.'s physical injuries, self-injurious behavior and side effects.

59. During Pl.'s next telepsychiatry appointment with Def. Dr. Vu, Pl. explained to Def. that Pl. had to go to suicide watch because of side effects, that Pl. hadn't been feeling well. Def. Vu asked how Pl. was feeling then. Pl. stated, "I'm having insomnia and rapid muscle, face movements and grinding of teeth, constipation, pain in my stomach, induced psychosis, blackouts, and I've been self injuring. Some injuries I don't remember doing." Def. Vu stated, "I hope you do well. I'll see you next week." Pl. received no treatment or medical intervention.

60. On or around 03/20/2023, Pl. interviewed with L. Lulow for a grievance. At that time, L. Lulow stated to Pl. that in his [qualified] opinion, Pl. needed a higher level of care, more intensive mental health treatment. L. Lulow stated he was disappointed in L. Lulow's

supervisors. L. Lulow stated his supervisor Def. T. Sparks had stated to mental health staff that Def. T. Sparks would not help Pl. because Def. T. Sparks thought Pl. was "evil" and that "you can't cure evil." Def. had told Pl. and that Pl. should be punished for his crimes. L. Lulow stated he didn't realize his supervisors were like that, that he was disappointed in such medieval thinking, and that L. Lulow couldn't believe these supervisors were allowing Pl. to stay in a dark, damp cell, alone, and known as harming himself and decompensating. L. Lulow stated that out of all people, Pl. didn't belong there.

61. Against L. Lulow's recommendations, Pl. did not receive more intensive treatment. Pl. received no safety/security regarding the broken window/shards and self-harm.

62. Around 02/2023-05/2025, meetings were held to raise Pl.'s level of care and brought to the attention of Defs. S. Gates, E. McDaniel, C. Soares, S. Harris that they wanted to raise or had raised Pl.'s level of care. Pl. was harming self/others and COs (Torres, Resendes, Balanga) filed 128-B Chronos stating Pl. was self-harming all of the time and had blood everywhere and was exhibiting bizarre, unusual behavior. Defs. S. Gates, E. McDaniel, C. Soares, S. Harris had stated to Pl.'s clinician and Treatment Team that Pl. was to stay in that unit and cell, excluded from treatment programs. The then notified Pl. that Defs., supervisors said that no, Pl. could not be moved and was excluded from treatment.

63. Pl. broke the other cell window and began using the bigger shards of glass to self-mutilate without intervention.

64. On or around 04/20/2023, unit officers Resendes, Ayala and RN Waite completed a 7219 medical/injury form on Pl.

65. On or around 04/28/2023, an incident occurred from Pl. having symptoms and side effects. Pl. received a write-up/RVR over the incident. Pl.'s arms were cut up at that time. A unit sgt. approached with RN Jane Doe. They asked Pl. if Pl. had any injuries and whether those injuries were from that same day. Pl. stated Pl.'s injuries were "from everyday going back from yesterday." Pl. was in and out of blackouts when they were asking Pl. questions. Pl. informed the sgt. that Pl. had not received mental health help/treatment and that Pl. had cuts to the bottoms of Pl.'s feet and should be moved to a safer cell. Pl.'s injuries were documented.

No further medical treatment or evaluations were given to Pl.

66. On or around 05/05/2023, Pl. stayed up all night cutting on himself.

67. On third watch, Pl. had a scheduled visit. Pl. was escorted to his visit with visible fresh wounds, and blood in/around his cell, which Def. Does, mental health and other prison staff during their multiple daily rounds and general duties around/with Pl. had seen but, against CDCR/State protocols/policies, had not intervened.

68. While Pl. was at visiting, Pl.'s visitor noticed the cuts on his arms. Again, Pl. responded that they [CSP-COR] were not concerned/didn't care and didn't intervene, that the unit sgt. stated that the warden wanted/required Pl. to be in that specific cell because of how the cell is designed. Even when staff acknowledged this had put and was putting Pl. in harm's way and contributing to Pl.'s injuries, that's how they [Warden and management] wanted it.

69. After the visit, Pl. was escorted back to his cell with the same broken window, bloody rags/debris on the floor. Pl. began cutting again and had active, noticeable bleeding.

70. The same day, Pl.'s visitor contacted RBGG informing them of what she had seen at the visit, expressing her concerns at how CSP-COR was not managing Pl.'s mental health episodes.

71. On that same day, RBGG contacted CSP-COR about Pl. and their concerns, and about the phone call they received from Pl.'s loved one.

72. Around 5 pm, because of RBGG's contact, Def. E. Moreno approached Pl.'s cell. Def. stated to Pl. that since there were no clinicians at CSP-COR after 4 pm there was no one to evaluate and clear the Pl., and that because of this Pl. had to be placed in the Crisis Unit until the morning when Pl. would come back to Pl.'s cell.

73. Def. E. Moreno asked if Pl. was bleeding. Pl. lifted his arm and showed Def. active bleeding from gashes in Pl.'s right arm. Def. E. Moreno asked Pl., "How long have you had the two broken windows?" and Pl. stated, "For around four months."

74. Def. Moreno stated that Pl.'s cell should have been red lined, tagged, closed off. Pl. stated that he had been cutting himself with glass for months and no one addressed the issue, that when he came out for visit no one cared that Pl. had blood everywhere, bloody rags.

75. Def. E. Moreno stated to Pl. that Pl.'s "friend needed to be careful what that friend says

because when/if suicide is mentioned they [CSP-COR] are forced to act." The actual policy is that upon any staff becoming aware/being put on notice of an inmate self-harming, that staff must stand post until clinical intervention presents to perform an evaluation. It was only being addressed now because RBGG had contacted CSP-COR. Pl. had previous grievances on Def. and when confront on the yard by Pl./inmate over the matters described in those grievances, Def. had stated that it was just "strictly business" and that he wasn't going to apologize.

76. Def. A. Aranda refused Pl.'s request to move to another cell.

77. Def. E. Moreno stated to Pl., "For now you have to go to Crisis. We're going to pull you out and Torres and Muhammad while you're gone will clean up your cell and I promise you'll be out by the morning."

78. Pl. then agreed and grabbed a piece of ripped sheet and tied off his arm to stop the bleeding.

79. Pl. was escorted to the Crisis Unit where Pl. was checked out at the Treatment Triage Area.

80. Def. Doe (RN) looked at Pl.'s wound, refused to clean it, stated, "Let suicide watch deal with it." Pl.'s arm was dripping with blood on the bed. The escorting unit officer stated to Def. Doe, "[Pl.] is bleeding. There's blood getting everywhere. Aren't you going to clean it?"

81. Def. Doe stated, "Let them do it. He may not be able to have the wrapping back there."

82. Def. E. Moreno told Pl. that the AW said, "You'll be discharged out by the morning."

83. The escorting unit officer stated to Pl., "They're always just sending you back and you continue to do the same thing. I don't understand."

84. Pl. was placed in Crisis Unit for around thirteen hours and discharged the next morning.

85. Pl. was then placed back in the same cell with the broken windows, with bloody toilet paper rolls, bloody, ripped up towels, inter alia, still on the floor.

86. During that same day, Pl. began to decompensate and used the glass shards to cut himself again without further treatment or intervention.

CAUSES OF ACTION

CLAIM ONE: EIGHTH AMDT. TO THE U.S. CONSTIT.; CONDITIONS OF CONFINEMENT

87. The actions/omissions of Def. A. Aranda (Lt.) failed to result in the immediate closing off of Pl.'s cell and failed to result in an order for Pl.'s cell windows to be fixed for around four

months. Def. failed to remove Pl. from the substantial risk when Def. was put on daily notice of incidents/injuries Pl. was suffering from the hazard of broken glass shards. Additionally, Def. was one of the supervisors who ordered Pl. not be moved for any reason from this cell. The actions and omissions of Def. A. Aranda demonstrated deliberate indifference, had constituted unsafe conditions of confinement, and violated Pl.'s right to be free of cruel and unusual punishment guaranteed under the Eighth Amdt. to the U.S. Constitution. Pl. has suffered, is suffering, and will continue to suffer irreparable harm, risk, and injuries/damages. As a proximate result of the Def.'s violations of Pl.'s right to be free from cruel and unusual punishment, Pl. suffered the above-described injuries/damages while in CSP-COR.

88. The actions and omissions of Def. warden T. Campbell, in failing to provide reasonable safe conditions of confinement, safe living conditions of confinement, and ordering the unsafe living conditions against the Pl., who has a serious mental illness and disabilities, in segregation. Def. acted maliciously and sadistically for the very purpose of causing harm to Pl. Def. upheld very severe restrictions imposed on Pl. who was in a disciplinary segregation unit at a special sanction designated to alter his extremely dangerous, deranged conduct from serious mental illness symptoms, causing Pl. an unnecessary and wanton infliction of pain and physical injuries. Def. T. Campbell was informed weekly when she would be in the unit running ICC by officers about Pl.'s repeated, consistent injuries he suffered on a daily basis and how the window was contributing to the injuries and the Pl. should be moved. Def. ignored these recommendations and stated the cell was a specially made assigned cell for Pl. and that Pl. had to stay there. Def. refused to red line the cell and fix the window. Def. was made aware daily that the Pl. had blood all over his cell floor, caking/stacking up and unsanitary rags and toilet paper rolls and that the Pl. had injuries. Def. refused to provide treatment even in a medical emergency response, such as self-injurious behavior. For the majority of the four months, Pl. did not receive treatment for around 95% of those four months and continued with new self-injuries every day without treatment or any intervention. Def. continued to state that Pl. has to stay in isolation, in extreme isolative conditions of confinement, and that Pl. was excluded from higher levels of care treatment and would stay in

Ad-Seg for being a danger to self/others, and gravely disabled and lacking capacity. Def. was aware of Pl.'s serious mental illness and aware of the PC 2602 order and its side effects and symptoms of mental illnesses and his treatment to refrain from compulsory self-harm and that by leaving the Pl. in the cell, that the likelihood that the Pl. would continue to receive injuries was high/likely and which he did. Def. took no action for all the months to make safe, sanitary living quarters for Pl. and others. Def. denied Pl. basic human needs, such as sanitation, personal safety, safe conditions, and medical care. Def. singles Pl. out from other inmates and dictates the outcome of Pl.'s medical and mental health treatment. Def. left the Pl. for weeks in puddles of blood with severe physical injuries and supported other Defs. to not provide any treatment to Pl. but was/were providing treatment to other inmates. The physical injuries Pl. suffered were due to the actions and omissions of Def. and due to Pl.'s injuries not being treated, it has caused Pl. severe pain, and suffering, who had to close his own wounds after injuring himself. The actions of Def. violated Pl.'s Eighth Amdt. Constitutional rights, causing physical injuries and unnecessary and wanton infliction of severe pain.

89. The actions/omissions of Def. B. McKinney failed to result in providing Pl. reasonable safety, which as Associate Warden was her mandatory duty to provide. Def. allowed/ordered Pl.'s unsafe conditions of confinement. Additionally, on 05/05/2023, Def. pre-determined and ordered to/through Def. E. Moreno that Pl. be discharged from Crisis Unit the next morning and returned to Pl.'s hazardous cell. The next morning, Pl. was discharged from Crisis Unit and Pl. was returned to the hazardous, bloodied cell that still had two broken windows. Def. B. McKinney, since around 01/15/2023, was consistently put on notice of the injuries of and hazards posed to Pl. Def. continued to take no action for four months. Even upon the order of a unit CO to keep Pl. on suicide watch and move Pl. to another cell, Def. still failed to take action. The actions/omissions of Def. B. McKinney resulted in Pl. remaining in inhumane, hazardous conditions for four months with broken glass everywhere, bloody debris. The actions/omissions of Def. B. McKinney resulted in Pl. being in continuous pain and caused the consistent back-to-back incidents of injuries, and nerve damage with overall loss of feeling in Pl.'s right arm and shooting pains to fingertips and keloid (raised/bulging) scarring. Pl. has

suffered, is suffering, and will continue to suffer irreparable harm, risk, and injuries/damages. Def.'s actions/omissions constituted unsafe conditions of confinement and violated Pl.'s right to be free of cruel and unusual punishment guaranteed under the Eighth Amdt. to the U.S. Constitution. As a proximate result of Def.'s violations of Pl.'s right to be free from cruel and unusual punishment, Pl. suffered the above-described injuries/damages while in CSP-COR.

90. The actions, omissions of Def. E. Moreno, in creating unsafe conditions of confinement, and failing to take action to known risk and harm against the Pl., practiced customs and departed from professional, mandated protocols and procedures that are in place to keep the safe custody of inmates. Def. failed on 05/05/2023 to redline and close down Pl.' s cell when Pl. was escorted to Crisis Unit. Other officers, such as Torres, Muhammed, cleaned some of the blood up, but the Def. still allowed afterwards for Pl.'s cell to be open and allowed Pl. to return to the same location, in which Pl. suffered further physical injuries and unnecessary, wanton infliction of pain. Def. departed from normal policy and procedure that mandates when certain items are broken in cells, such as the toilet, mechanical door, and especially broken windows that block observation of custody and inmates, and due to the shards of glass causing harm, that these cells must be closed down for repair. Def., before the incident, acted maliciously and sadistically against the Pl. for the very purpose of causing harm and threatened the Pl.'s life and has told the Pl. that he's not going to apologize that it's "strictly business," and Pl. has past complaints of staff misconduct against the Def. Def. was aware of the unsanitary and unsafe conditions that were a threat not only to Pl. but also to correctional officers, other personnel. Def.'s actions in allowing Pl. to return to the cell contributed to further physical injury and unnecessary, wanton infliction of pain that resulted in the overall loss of feeling in Pl.'s right arm, shooting sharp pains to fingertips and numbness of Pl.'s fingertips, and extreme scarring. Def. knew that due to Pl.'s severe mental illness and PC 2602 order that at times Pl. is unable to make his needs met because of psychosis, other symptoms where the Pl. blacks out or hallucinates and harms himself/others.

91. The actions and omissions of Def. T. Sparks in creating, ordering the practices and customs departing from CDCR professional procedures and protocols against the Pl., creating unsafe

living conditions of confinement and acting maliciously and sadistically for the very purpose of causing harm to Pl., and upholding very severe restrictions imposed on Pl. who was in a disciplinary segregation unit as a special sanction designated to alter the extremely dangerous conduct from symptoms of Pl.'s serious mental illness and side effects from PC 2602, led to significant physical injuries and unnecessary, wanton infliction of pain. The Def. has expressed that the Pl. was "evil" and "couldn't be cured" and what's the point in sending Pl. to a higher level of care if he's not just going to come out anyways. Def. was made aware by RBGG that Def. had to respond to Pl.'s cell and provide treatment due to the medical emergency of inflicted injuries and other emergency response health conditions. Def. approached Pl.'s cell with a Psych Tech and asked to see Pl.'s injuries and when Pl. lifted up his arms, the Psych Tech stated, "Wow" in Spanish and expressed how bad it was, a large gash, deep in the middle of Pl.'s arm around several inches long. Def. and the Psych Tech walked away, violating protocol. Def. stated that she had an email from RBGG and that, "I need a reason to walk away." Def. told Pl. to promise not to self-harm anymore. Def. did not have officers pull Pl. out to retrieve the cutting instrument nor were the Pl.'s injuries cleaned or treated by medical staff. Pl. was left to try to treat his own injuries and avoid infection. The actions and omissions of Def. resulted in Pl.'s further injuries. The Def.'s decisions were so grossly incompetent, inadequate, and excessive as to shock the conscious and to be intolerable to the fundamental fairness. Def. denied Pl. access to treatment. Def. knew that the Pl. met the qualifications for more intense treatment at a higher level of care, even at the acute level of care, so the Pl. could be stabilized, and the Pl. and others could be safe. Def. ignored the mental health delivery system guidelines, and ignored the adequate, modern science and has even denied that side effects exist and has failed to meet the health care standards that are mandated and reasonably designed to meet the routine and emergency medical, dental, and psychological or psychiatric care. Def.'s actions, omissions created unsafe conditions of confinement and caused significant injury, unnecessary, wanton infliction of pain, was grossly inadequate psychiatric care, and violated Pl.'s Eighth Amdt. rights.

92. The actions/omissions of Def. A. Johnson, after Def. was put on notice of the broken cell

windows and that Pl. was sustaining injuries from broken glass, failed to result in ordering Pl.'s cell closed off and fixed for around four months. Def. failed to remove Pl. out of the substantial risk, which failure ensured Pl. continued to sustain injuries. Def., as the building's captain, was consistently present within the unit and reasonably aware of the state/conditions of that building and its inmates, was reasonably aware of the blood all over Pl.'s cell, and Pl.'s in-cell conditions that was hazardous both to Def.'s staff and Pl. Def. failed to provide or summon a hazmat cleaning team and had denied Pl. basic cleaning necessities. Def. was on notice of Pl.'s diagnoses of serious mental illnesses because Def. participates in and is a main decision maker in Pl.'s monthly IDTT/treatment committee meetings. One purpose of these IDTT meetings is reviewing Pl.'s housing assignment and incidents/occurrences. Def. at every opportunity failed to take adequate action and failed to direct orders to his staff under his charge to take adequate action. Additionally, Def. tolerated inadequate mental health treatment by CSP-COR's mental health staff. Unit officers J. Munoz, I. Torres, Resendes, and Balanga wrote/submitted 128-D Chronos in documenting Pl.'s state/living conditions and how these unit officers tried to address the above-described/omitted incidents. These officers' supervisors, including Def. A. Johnson, instead of following State/CDCR protocols/polices had overridden these officers' decisions/recommendations to provide adequate treatment/care to/for Pl., which these officers then reported this to Pl. These officers' 128-D Chronos clearly established Pl.'s behaviors and injuries and how these officers tried addressing it. Def. A. Johnson, as unit captain, was on notice of such 128-D Chronos and or had direct access to these documents. The actions/omissions of Def. A. Johnson resulted in Pl. remaining in inhumane, hazardous conditions for four months with broken glass everywhere, bloody debris. It resulted in Pl. remaining in continuous pain, had caused the consistent back-to-back incidents of injuries, and nerve damage with overall loss of feeling in Pl.'s right arm and shooting pains to fingertips and keloid (raised/bulging) scarring. Pl. has suffered, is suffering, and will continue to suffer irreparable harm, risk, and injury/damage. Def. A Johnson's actions/omissions constituted unsafe conditions of confinement and violated Pl.'s right to be free of cruel and unusual punishment guaranteed under the Eighth Amdt. to the U.S.

Constitution. As a proximate result of Def.'s violations of Pl.'s right to be free from cruel and unusual punishment, Pl. suffered the above-described injuries/damages while in CSP-COR.

93. The actions and omissions of Def. Does, in participating and ordering the practices and customs departing from normal procedures, acted maliciously, sadistically with the very purpose of causing Pl. harm to uphold very severe restrictions imposed on Pl. who was in a disciplinary segregation unit as a special sanctioned design to alter his extremely dangerous conduct due to severe mental health symptoms, as a danger to self/others, gravely disabled, lacks capacity. Def. Does, in creating practices and customs that do not support staff in responding to emergency situations and threats to self-injure, self-harm, and dangerous side effects to medications such as seizures, onset of stroke, numbness to the left arm/face, suicidal ideation, and the current observable physical injuries, created conditions of unsanitary living conditions, had allowed weeks and weeks of bloodied debris and dried blood to be all over the tier and doors and floor and had not responded to Pl.'s emergency medical needs and injuries when made aware and had not red-lined the cell and moved Pl. to a safer location. The actions, omissions of Def. Does constituted unsafe conditions of confinement and were deliberate indifference for knowing the known risk and imminent danger and harm that Pl. was in and failed to take any action to provide safe custody for Pl. and created an environment that made Pl.'s conditions and injuries worse, causing unnecessary, wanton infliction of pain and suffering, violating Pl.'s Eighth Amdt.

CLAIM TWO: EIGHTH AMDT. TO THE U.S. CONSTIT.; DELIBERATE INDIFFERENCE TO SERIOUS MENTAL HEALTH/MEDICAL NEEDS

94. The actions and omissions of Def. T. Sparks, in acting with deliberate indifference to Pl.'s serious mental health medical needs, knew of and disregarded an excessive risk of serious harm to inmates' health and safety and failed to carry out psychotropic medical orders. Def. was made aware weekly by staff and by personal observation of Pl.'s physical injuries and symptoms every day and allowed Pl. to stay in the cell with a cutting instrument and failed to order Pl. to receive medical treatment and secure the instrument. Def. was made aware by COs who worried of the living conditions and health of Pl., Pl.'s mental health, and that Pl. had

layers of fresh blood stacked on the floor with a lot of flies, roaches, bloody towels, toilet paper rolls, content, and of two broken windows, and that Pl. was being injured from the glass. Pl. expressed his symptoms and side effects that lead to injuries. Def. refused to treat Pl. due to her belief that Pl. was "evil" and "evil can't be cured" and due to her anger about Pl.'s complaints against them, and RBGG's class actions against mental health that Pl. gave statements for. Def. failed to carry out CDCR-petitioned medical orders for a psychotropic medical. Def. failed to act on medical recommendations by order from a petitioned administrative judge for CDCR who also ordered that Pl. must be monitored on periodic basis to determine if the drugs 1.) were causing any harmful side effects 2) if the drugs were working the way the psychiatrist intends for it to work. Def. knows Coleman v. Wilson, Coleman v. Newsom court orders, and that adequate prison mental health care requires administration of psychotropic medications only with supervision and periodic evaluation. Def. has a Constitutional duty to adequately monitor inmates' prescription psychotropic medication whether they require such monitoring or not. Def. was aware of the facts which was detailed information about the danger Pl. was in which the inference was drawn that a substantial risk of serious harm existed and Def. failed to embrace a policy or take other reasonable steps which could have prevented the harm and continued harm. Def.'s actions resulted in Pl. suffering unnecessary, wanton infliction of pain and physical injuries, deeply cut up arms, legs, feet which out of all four months had not received treatment once, leaving Pl. with numbness in fingertips, shooting pain down through his hands, inter alia. Def.'s actions constituted deliberate indifference to serious mental health medical needs, was grossly inadequate psychiatric care, and violated Pl.'s Eighth. Amdt. rights.

95. The actions and omissions of Def. D. Watson in acting with deliberate indifference to Pl.'s serious mental health medical needs, knew of and disregarded an excessive risk of serious harm to Pl.'s health and safety, and failed to carry out medical orders of a psychotropic medical petition. When Def. approached Pl.'s cell for their weekly one-on-ones which Pl. would not attend due to his decompensated state, Pl. told, informed Def. that he had been cutting on himself, having blackouts and having side effects and symptoms to psychotropic

medications. Pl. stated, and Def. observed Pl.'s injuries with active bleeding, and the unsanitary living conditions of Pl.'s cell with layers of blood, bloody contents. Pl. informed Def. that Pl. was cutting with glass from the window and a cutting instrument and that sometimes Pl. would blackout and wake up and have injuries. The Def. would just walk away, stating, "Okay, see you next week." Pl. received no treatment for his injuries and continued to suffer injuries. Def. failed to carry out CDCR petition medical orders for psychotropic medical and failed to act on medical recommendations by order from a petition administrative judge for CDCR who ordered that Pl. must be monitored on periodic basis to determine if the drugs 1.) were causing any harmful side effects; and, 2) if the drugs were working the way the psychiatrist intends for it to work. Def. knows Coelman v. Wilson, Coleman v. Newsom court orders that adequate prison mental health care requires administration of psychotropic medications only with supervision and periodic evaluation. Def. has a Constitutional duty to adequately monitor inmates on prescription psychotropic medication whether they request such monitoring or not. Def. was aware of the facts which were detailed information about the danger Pl. was in, which the inference was drawn that a substantial risk of serious harm existed and Def. failed to embrace a policy or take other reasonable steps which should have prevented the harm and continued harm. Def.'s actions resulted in Pl. suffering unnecessary, wanton infliction of pain, physical injuries, deeply cut up arms, legs, feet, which out of all four months had no treatment even once, leaving Pl. with numbness in fingertips, shooting pain down through his hands. Def.'s actions constituted deliberate indifference to serious mental health medical need, was grossly inadequate psychiatric care, violated Pl.'s Eighth. Amdt. rights.

96. The actions and omissions of Def. S. Harris, in acting with deliberate indifference to Pl.'s serious mental health medical needs, knew of and disregarded an excessive risk of serious harm to Pl.'s health and safety. Def. intentionally intervened with the treatment prescribed, and denied Pl. access to treatment, and failed to carry out medical orders, and failed to act on medical recommendations that he forced the petitioning psychiatrist to force on Pl. The Def. was made aware weekly that Pl. was cutting on himself, was having symptoms and side effects and had bizarre, unusual, deranged behaviors, that his clinician stated in meeting that Pl.'s

ADLs were not being met, Pl. was not coming out of his cell due to paranoia, and that it was ordered due to Pl.'s/others' safety that Pl. needed higher level of care. L. Lulow granted a health care grievance stating that Pl. needed a higher level of care that would restore Pl. to stability, normalcy. Def. reviewed and decided grievances against himself and intervened on both occasions, ordering L. Lulow to change his grievance findings. Def. then later somehow cancelled Pl.'s bed move and transfer, and clinician C. Angel told Pl. that her supervisors got in the way. This shocked COs because officers were being harmed in the process. Def. stated, agreed that Pl. was evil and that evil cannot be cured and what's the point if Pl. is not going to come out anyways. Right after Def. intervened, Def. then ordered Pl. to stay in the same cell with broken windows. Pl. then suffered more injuries and continued to suffer side effects and symptoms that led to more physical injuries. Def. failed to carry out CDCR petition medical orders for psychotropic medical and failed to act on medical recommendations by orders from a petition administrative judge for CDCR who ordered that Pl. must be monitored on periodic basis to determine if the drugs 1.) were causing any harmful side effects; and , 2) if the drugs were working the way the psychiatrist intends for it to work. Def. knows Coelman v. Wilson, Coleman v. Newsom court orders that adequate prison mental health care requires that administration of psychotropic medications is only with supervision and periodic evaluation. Def. has a Constitutional duty to adequate monitor inmates on prescription psychotropic medication whether they request such monitoring or not. Def. was aware of the facts which was detailed information about the danger Pl. was in which the inference was drawn that a substantial risk of serious harm existed and Def. failed to embrace a policy or take other reasonable steps, which should have prevented the harm and continued harm. Def.'s actions resulted in Pl. suffering unnecessary, wanton infliction of pain and physical injuries, deeply cut up arms, legs, feet, which out of all four months had no treatment even once, leaving Pl. with numbness in fingertips, shooting pain down through his hands. Def.'s actions constituted deliberate indifference to serious mental health medical need, was grossly inadequate psychiatric care and violated Pl.'s Eighth. Amdt. rights.

97. The actions and omissions of Def. S. Gates, in acting with deliberate indifference to Pl.'s

serious mental health medical needs, knew of and disregarded an excessive risk of serious harm to Pl.'s health and safety. Def. intentionally intervened with the treatment prescribed, and denied Pl. access to treatment, and failed to carry out medical orders, and failed to act on medical recommendations that he forced the petitioning psychiatrist to force on Pl. The Def. was made aware weekly that Pl. was cutting on himself, was having symptoms and side effects and had bizarre, unusual, deranged behaviors, that his clinician stated in meeting that Pl.'s ADLs were not being met, Pl. was not coming out of his cell due to paranoia, and that it was ordered due to Pl.'s/others' safety that Pl. needed higher level of care. L. Lulow granted a health care grievance stating that Pl. needed a higher level of care that would restore Pl. to stability, normalcy. Def. reviewed and decided grievances against herself and intervened on both occasions, ordering L. Lulow to change his grievance findings. Def. then later somehow cancelled Pl.'s bed move and transfer, and clinician C. Angel told Pl. that her supervisors got in the way. This shocked COs because officers were being harmed in the process. Def. stated, agreed that Pl. was evil and that evil cannot be cured and what's the point if Pl. is not going to come out anyways. Right after Def. intervened, Def. then ordered Pl. to stay in the same cell with broken windows. Pl. then suffered more injuries and continued to suffer side effects and symptoms that led to more physical injuries. Def. failed to carry out CDCR petition medical orders for psychotropic medical and failed to act on medical recommendations by orders from a petition administrative judge for CDCR who ordered that Pl. must be monitored on periodic basis to determine if the drugs 1.) were causing any harmful side effects; and , 2) if the drugs were working the way the psychiatrist intends for it to work. Def. knows Coelman v. Wilson, Coleman v. Newsom court orders that adequate prison mental health care requires that administration of psychotropic medications is only with supervision and periodic evaluation. Def. has a Constitutional duty to adequate monitor inmates on prescription psychotropic medication whether they request such monitoring or not. Def. was aware of the facts which was detailed information about the danger Pl. was in which the inference was drawn that a substantial risk of serious harm existed and Def. failed to embrace a policy or take other reasonable steps, which should have prevented the harm and continued harm. Def.'s actions

resulted in Pl. suffering unnecessary, wanton infliction of pain and physical injuries, deeply cut up arms, legs, feet, which out of all four months had no treatment even once, leaving Pl. with numbness in fingertips, shooting pain down through his hands. Def.'s actions constituted deliberate indifference to serious mental health medical need, was grossly inadequate psychiatric care and violated Pl.'s Eighth. Amdt. rights.

98. The actions/omissions of Def. Dr. Vu, in acting with deliberate indifference to Pl.'s serious mental health medical needs, knew of and disregarded excessive risk of serious harm to Pl.'s health and safety, refusing to respond to serious physical injuries, an emergency response to life-threatening psychotropic medical side effects, threats of self-harm, failed to carry out medical orders, psychotropic medical orders, CDCR petition administrative judge court orders. Def. Vu, a psychiatrist doctor, when approaching Pl.'s cell every other week, was informed by Pl. that Pl. was self-harming and had physical, deep-cut wounds and active bleeding, new injuries minutes before Def. approached his cell and that Pl. had been having side effects to psychotropic medication and blackouts. Def. walked away, failed to inform staff of the security emergency, medical emergency that Pl. had a cutting instrument in his cell that needed to be secured. Def. failed to observe Pl. until staff and medical arrived, which is a mandatory emergency response under the court order of Coleman v. Newsom and is a medical emergency. When inmates under PC 2602 state they are having side effects, they must be sent to the hospital/medical. When Def. walked away, Pl. continued to receive injuries from the broken window glass and to have symptoms and side effects untreated. Def. was aware of facts from which he could draw inference with the information that Pl. provided to him that a substantial risk of serious harm existed. Def. failed to embrace policy or take any other reasonable steps which could have prevented harm. Def. has a Constitutional duty to adequately monitor inmates on prescribed psychotropic medicals whether they request such monitoring or not. All inmate patients on psychotropic medicals must be monitored on periodic basis to determine if the drugs give harmful side effects or if the drug is working the way the doctor intended for it to work. Def.'s actions were grossly inadequate psychiatric care and violated Pl.'s Eighth Amdt. rights.

99. The actions and omissions of Def. E. McDaniel, in creating unsafe conditions of confinement, in making decisions against Pl., putting Pl. in substantial harm to his health and safety and not taking action when being put on notice that Pl. had two broken windows, and was cut up by the glass, and was having mental health symptoms from his mental illnesses where Pl. would self-harm, Def. chose to keep Pl. in extreme isolative conditions of confinement, separated from ordinary care of others to exasperate Pl.'s dangerous conditions due to mental illnesses symptoms. Def. on multiple occasions and meetings when Pl.'s level of care was raised for Pl. to be shipped out, Def. had another meeting, separately, and ordered that Pl. was excluded from higher levels of care and was not allowed. Def. on multiple occasions, when overturning transfers, stated Pl. was excluded. Pl. was informed by his clinician and Treatment Team that Def. had it in file that Pl. was not allowed to access treatment programs. Def. expressed, agreed that Pl. was evil and evil cannot be cured and that Pl. should be punished for his crimes. When Def. was put on notice of Pl.'s injuries, Def. ordered Pl. to stay in that mental health unit cell and Pl. continued to suffer injuries after Def.'s order. Def.'s actions resulted in Pl. to further receive deep cut wounds, shooting pains, numbness, side effects and symptoms untreated, left with the two broken windows, falling on his head with seizures going untreated, and other side effects. Pl. suffered day-to-day for 4 months and further decompensated. Def. admitted Pl. was self-harming daily and decompensating, stating Pl. was a danger to self/others, gravely disabled, in order to renew PC 2602 order against Pl., yet Def. failed to carry out medical orders for psychotropic medical, continued to create grossly inadequate psychiatric care for Pl. that has been based on severe punishment rather than treatment. Def. knew adequate prison mental health care administration of psychotropic medications required appropriate supervision and periodic evaluation. Def. refused to accept that the psychotropic medication Pl. received gave side effects. Def. chose to ignore the doctor's orders, petition, and Pl. was forced to continue the prescriptions or be cell extracted. Def. refused to treat Pl. for the doctors' orders by a CDCR petition administrative judge and Pl. suffered unnecessary, wanton infliction of pain and Pl. suffered injuries on a daily basis, sometimes sitting in puddles of blood with cut wounds everywhere on arms, legs, feet, untreated. Def.'s actions were grossly inadequate

psychiatric care and violated Pl.'s Eight Amdt. rights.

00. The actions and omissions of Def. C. Soares, in creating unsafe conditions of confinement, in making decisions against Pl., putting Pl. in substantial harm to his health and safety and not taking action when being put on notice that Pl. had two broken windows, and was cut up by the glass, and was having mental health symptoms from his mental illnesses where Pl. would self-harm, Def. chose to keep Pl. in extreme isolative conditions of confinement, separated from ordinary care of others to exasperate Pl.'s dangerous conditions due to mental illnesses symptoms. Def. on multiple occasions and meetings when Pl.'s level of care was raised for Pl. to be shipped out, Def. had another meeting, separately, and ordered that Pl. was excluded from higher levels of care and was not allowed. Def. on multiple occasions, when overturning transfers, stated Pl. was excluded. Pl. was informed by his clinician and Treatment Team that Def. had it in file that Pl. was not allowed to access treatment programs. Def. expressed, agreed that Pl. was evil and evil cannot be cured and that Pl. should be punished for his crimes. When Def. was put on notice of Pl.'s injuries, Def. ordered Pl. to stay in that mental health unit cell and Pl. continued to suffer injuries after Def.'s order. Def.'s actions resulted in Pl. to further receive deep cut wounds, shooting pains, numbness, side effects and symptoms untreated, left with the two broken windows, falling on his head with seizures going untreated, and other side effects. Pl. suffered day-to-day for 4 months and further decompensated. Def. admitted Pl. was self-harming daily and decompensating, stating Pl. was a danger to self/others, gravely disabled, in order to renew PC 2602 order against Pl., yet Def. failed to carry out medical orders for psychotropic medical, continued to create grossly inadequate psychiatric care for Pl. that has been based on severe punishment rather than treatment. Def. knew adequate prison mental health care administration of psychotropic medications required appropriate supervision and periodic evaluation. Def. refused to accept that the psychotropic medication Pl. received gave side effects. Def. chose to ignore the doctor's orders, petition, and Pl. was forced to continue the prescriptions or be cell extracted. Def. refused to treat Pl. for the doctors' orders by a CDCR petition administrative judge and Pl. suffered unnecessary, wanton infliction of pain and Pl. suffered injuries on a daily basis,

sometimes sitting in puddles of blood with cut wounds everywhere on arms, legs, feet, untreated. Def.'s actions were grossly inadequate psychiatric care and violated Pl.'s Eight Amdt. rights.

101. The actions and omissions of Def. M. Whittaker, in creating unsafe conditions of confinement, in making decisions against Pl., putting Pl. in substantial harm to his health and safety and not taking action when being put on notice that Pl. had two broken windows, and was cut up by the glass, and was having mental health symptoms from his mental illnesses where Pl. would self-harm, Def. chose to keep Pl. in extreme isolative conditions of confinement, separated from ordinary care of others to exasperate Pl.'s dangerous conditions due to mental illnesses symptoms. Def. on multiple occasions and meetings when Pl.'s level of care was raised for Pl. to be shipped out, Def. had another meeting, separately, and ordered that Pl. was excluded from higher levels of care and was not allowed. Def. on multiple occasions, when overturning transfers, stated Pl. was excluded. Pl. was informed by his clinician and Treatment Team that Def. had it in file that Pl. was not allowed to access treatment programs. Def. expressed, agreed that Pl. was evil and evil cannot be cured and that Pl. should be punished for his crimes. When Def. was put on notice of Pl.'s injuries, Def. ordered Pl. to stay in that mental health unit cell and Pl. continued to suffer injuries after Def.'s order. Def.'s actions resulted in Pl. to further receive deep cut wounds, shooting pains, numbness, side effects and symptoms untreated, left with the two broken windows, falling on his head with seizures going untreated, and other side effects. Pl. suffered day-to-day for 4 months and further decompensated. Def. admitted Pl. was self-harming daily and decompensating, stating Pl. was a danger to self/others, gravely disabled, in order to renew PC 2602 order against Pl., yet Def. failed to carry out medical orders for psychotropic medical, continued to create grossly inadequate psychiatric care for Pl. that has been based on severe punishment rather than treatment. Def. knew adequate prison mental health care administration of psychotropic medications required appropriate supervision and periodic evaluation. Def. refused to accept that the psychotropic medication Pl. received gave side effects. Def. chose to ignore the doctor's orders, petition, and Pl. was forced to continue the

prescriptions or be cell extracted. Def. refused to treat Pl. for the doctors' orders by a CDCR petition administrative judge and Pl. suffered unnecessary, wanton infliction of pain and Pl. suffered injuries on a daily basis, sometimes sitting in puddles of blood with cut wounds everywhere on arms, legs, feet, untreated. Def.'s actions were grossly inadequate psychiatric care and violated Pl.'s Eight Amdt. rights.

PRAYER FOR RELIEF

WHEREFORE, Pl. respectfully requests that the Court grant the following relief:

A. Issue declaratory judgement statements;

B. Issue compensatory damages:

a. $ 800,000 weekly for the four months Pl. was left untreated with known hazardous/unsafe conditions of confinement, and Pl.'s permanent disfigurement, and nerve damage, and pain.

b. $ 250,000 per Def. found to have acted in deliberate indifference/in negligence of their mandatory duties.

c. For all punitive damages in an amount appropriate to punish the Def. and make an example of the Def. to the community.

d. For any additional general and or specific, consequential and or incidental damages in an amount to be proven at trial.

e. For all nominal damages.

f. For all interests, where/as permitted by law.

C. Issue injunction orders;

D. GRANT any such other relief as may appear that Pl. is entitled.

DEMAND FOR JURY TRIAL

Pl. demands a trial by jury on all issues triable by jury.

Respectfully submitted on June 01, 2025,

p.p. Jamie Osuna, CDCR # BD0868

Notice to Magistrate Judge,

Plaintiff is filing his first amended complaint for 1:24-cv-01156-JLT-EPG under FRCP 15a. Plaintiff recently found defects and mistakes in his original complaint from when Plaintiff was having his complaint transcribed to type 12 font due to the 25-page limit from a non-e-filed complaint. Plaintiff had many defendants and had exceeded the 25-page limit so that when Plaintiff was transcribing the handwritten to type, words and writing were shortened, abbreviated that Plaintiff found now and which oversight meant that some were shortened and words used that may not have meant the same meaning. Although Pl.'s factual allegation is in great detail of the physical injuries and the serious risk and harm that defendants knew of and where inference could be drawn of serious risk of harm to Plaintiff's health and safety, the mental health defendants excluded Plaintiff from treatment programs and ordered him to remain in the cell, and so forth, and due to that 25-page limit, Plaintiff had to choose to shorten the counts and name all defendants or to do 25-pages and keep defendants out of Pl.'s original complaint. Plaintiff tried to get as close to 25-pages as possible. Plaintiff apologizes to the Magistrate Judge for the last objection and Plaintiff wishes the Magistrate Judge to understand and allow the Plaintiff to exercise his right under Rule 15a. Plaintiff has not engaged in an undue delay nor in bad faith that would fail to save a complaint from dismissal because to fix Plaintiff's deficiencies and mistakes would help the outcome of the complaint.

Respectfully submitted on June 01, 2025,

p.p. Jamie Osuna, CDCR # BD0868